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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

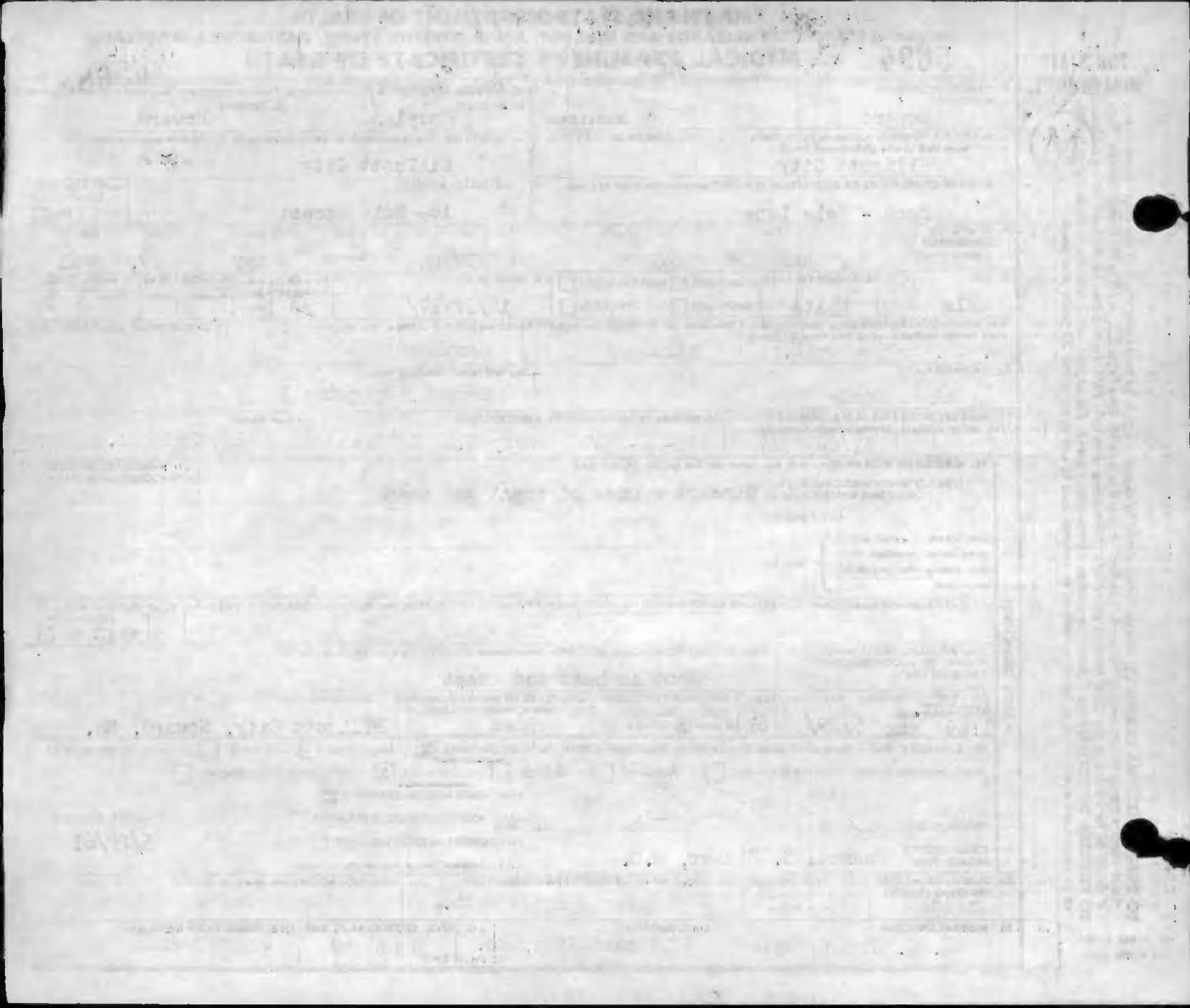
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 6288 6/12/63

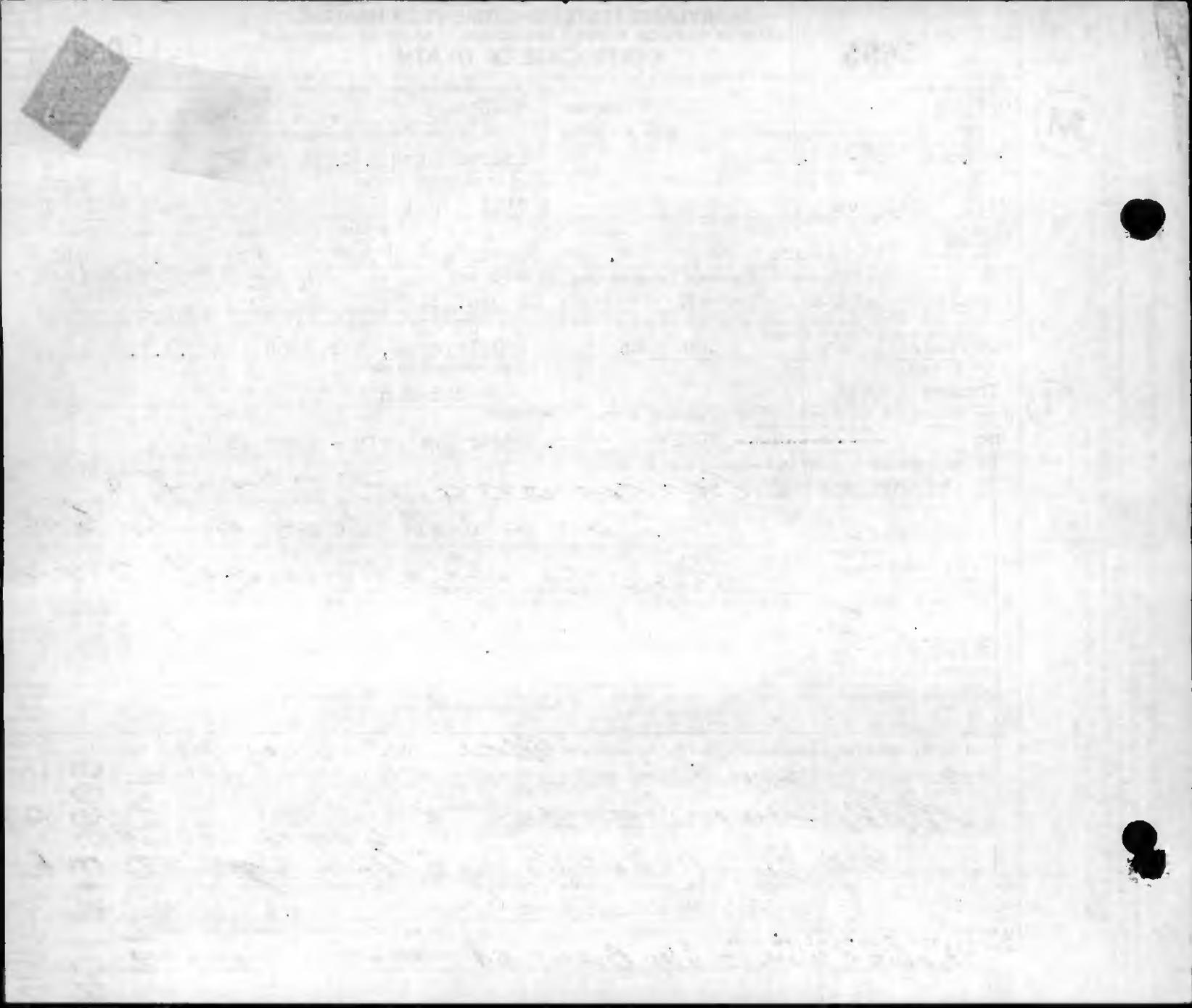
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Howard | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City | | b. COUNTY Howard | |
| c. LENGTH OF STAY IN 1b Road - Fels Lane | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Randolph Hospital | | d. STREET ADDRESS 189 Main Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) RANDOLPH EUGENE | | First RANDOLPH | Middle EUGENE |
| 4. DATE OF DEATH May 29, 1961 | | Last May | Month 29 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| 8. DATE OF BIRTH 12/22/27/ | | 9. AGE (in years last birthday) 32 33 yrs. | 10. IF UNDER 1 YEAR Months 3 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ho. Co. Police Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY Patrolman | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Dalmas Davis | | 14. MOTHER'S MAIDEN NAME Mary C. Brightwell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) Yes 1946-1948 | | 16. SOCIAL SECURITY NO. 212-24-2917 | 17. INFORMANT Mary C. Brightwell |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | Address 189 Main St. Ellicott City | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of chest and head | | INTERVAL BETWEEN ONSET AND DEATH | |
| 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | DUE TO | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot in head and chest | |
| 20c. TIME OF INJURY Month, Day, Year Approx. a.m. 1:45 5/29/61 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road |
| 20f. (City or town) Ellicott City, Howard, Md. | | (County) Ellicott City, Howard, Md. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| ACTUAL SIGNATURE <i>B. S. Fisher</i> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | DATE SIGNED 5/29/61 | |
| 22b. DATE THEREOF 6/2/61 | | 22c. NAME OF CEMETERY OR CREMATORIUM Poplar Springs Meth. | |
| 22d. LOCATION (City, town, or county) Poplar Springs, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR F. C. Higinbotham | | ADDRESS Ellicott City, Md. | |
| 24a. REC'D BY REGISTRAR JUN 5 '61 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fisher</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5696

CERTIFICATE OF DEATH

Reg. Dist. No.

65685

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| 1. PLACE OF DEATH a. COUNTY HOWARD | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY HOWARD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSTOCK | | c. LENGTH OF STAY IN 1b 13 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSTOCK | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOODSTOCK COLLEGE | | e. STREET ADDRESS WOODSTOCK COLLEGE | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) REV. JOHN | | First HARDING | Middle FISHER S.J. | Last MAY | 4. DATE OF DEATH 4, 1961 | Month Day | Year Year |
| S. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH DEC. 9, 1875 | 9. AGE (In years last birthday) 85 yr. | IF UNDER 1 YEAR Months 0 | | IF UNDER 24 HRS. Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROMAN CATHOLIC PRIEST, JESUIT ORDER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BROOKLYN, N. Y. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT REV. JOHN L. BRUNETT | | Address B. J. WOODSTOCK, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 hr | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) Harold H. Burns , M.D. | |
| ACTUAL SIGNATURE Harold H. Burns , M.D. | | | | | | DATE SIGNED 5/5/61 | |
| PHYSICIAN'S NAME (Type) Harold H. Burns, M.D. | | 115 East Eager Street | | Balto. 2, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/6/61 | | 22c. NAME OF CEMETERY OR CREMATORIUM WOODSTOCK COLLEGE | | 22d. LOCATION (City, town, or county) WOODSTOCK | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. W. MEARS & SON | | ADDRESS 805 N. CALVERT ST. | | 24a. REC'D BY REGISTRAR DATE MAY 8 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5697

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65686

1. PLACE OF DEATH
a. COUNTY

Howard

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Rural - Ellicott City

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Gas Station - Junction Rt. 40 & 29

3. NAME OF
DECEASED
(Type or print)

First Middle

CHARLES

F.

GALLION JR.

4. SEX

6. COLOR OR RACE

Male

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

NOV. 1, 1929

31

9. AGE (in years
last birthday)

31

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SERVICE STATION ATT.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MP.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES F. GALLION SR.

14. MOTHER'S MAIDEN NAME

RUBY MC CLURE

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

216-24-2948 MRS PATRICIA L. GALLION, 316 ATHOL AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Gunshot wounds of chest and head with bilateral

INTERVAL BETWEEN
ONSET AND DEATH

98IX

hemothorax

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot in head and chest

20c. TIME OF INJURY Month, Day, Year

Appox. a.m.
1:45 AM 5/29/1961

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Gas Station

20f. (City or town)

Rural-Ellicott City, Howard,

(County)

Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/29/61

ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL 5/161

22b. DATE THEREOF

Loudon Pk.

22c. NAME OF CEMETERY OR CREMATORIUM

BALTO. MD.

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

MAY 31 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any time is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

V.S. A15ME
5M 9/60

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

45687

| | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------|-------------------------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Howard County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Howard County | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City | | c. LENGTH OF STAY IN TB | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City | | d. STREET ADDRESS Route #29 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #29 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Annie E. Jubb | | First | Middle | Last | 4. DATE OF DEATH May 29 1961 | Month | Day | Year | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 26, 1872 | 9. AGE (In years (last birthday) yrs.) 88 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Franklin C. Hall | | 14. MOTHER'S MAIDEN NAME Margaret Campbell | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT 217-05-2370 Mrs. Lawrence C. Mosner, R.#29, Ellicott City | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | Periphereal Vascular Collapse | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Ellicott City | | (County) Montgomery | (State) Maryland |
| 21. I certify that (I) (this hospital) attended the deceased from May 19 1960 to May 27 1961 , that (II) (we) last saw the deceased alive on May 29 1961 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Thomas F. Herbert, | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED 5-27-61 | | | |
| 22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D. | | 22d. ADDRESS Ellicott City, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 6-1-61 | | 23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery | | 23d. LOCATION (City, town, or county) 3310 Taylor Avenue | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE JUN 1 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

FOR STATE
HEALTH DEPT.

M

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

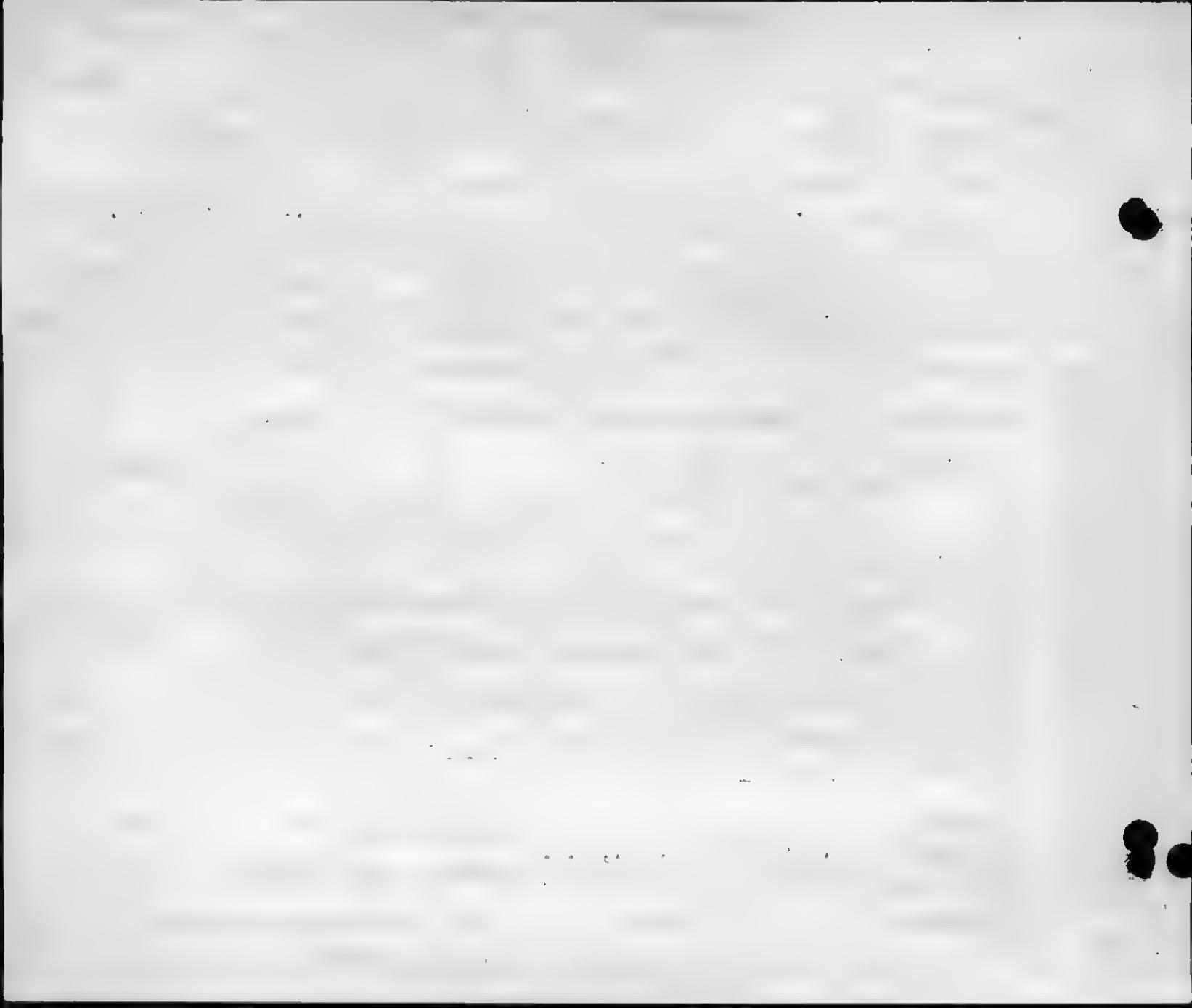
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65688

| | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Howard | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel | | c. LENGTH OF STAY IN 16 771/2 | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Howard | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel | | d. STREET ADDRESS Maple Hill Apts., All Saints Road | | e. IS RESIDENCE ON A FARM? NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) BETTY JEDETTA | | First Middle | | Last | | 4. DATE OF DEATH May 22 1961 | | Month Day Year | | 5. SEX Female White | | 6. COLOR OR RACE WIDOWED DIVORCED | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 26 May 1960 | | 9. AGE (In years last birthday) 1 yr. IF UNDER 1 YEAR Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? (Check one) U.S.A. | | Address | | 13. FATHER'S NAME P. K. | | 14. MOTHER'S MAIDEN NAME Eli King | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hydrocephalus | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH, | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE W. Bradley King, Jr., M.D. EXAMINER'S NAME (Type) | | DATE SIGNED 5/23/61 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/24/61 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cemetery National | | 22d. LOCATION (City, town, or county) Baltimore - Md. (State) | | 23. FUNERAL DIRECTOR ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | 24c. DATE MAY 25 '61 | | Address (Street, city, town, or county) Calvert & Hanover | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

15689

5700

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Howard | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat | | | | d. STREET ADDRESS 2728 Jefferson St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First MAMIE | Middle O. | Last MARSHALL | 4. DATE OF DEATH May 1, 1961. |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9-28-1884 | 9. AGE (in years last birthday) 76 yrs |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Owings Mills, Md | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Mrs. Chas. E. Angel, 818 Augusta Ave. Balto. 29, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic cardiovascular disease DUE TO (b) (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.] | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2-29 , 19 60 , to 5-1 , 19 61 , that I last saw the deceased alive on 4-30 , 19 61 , and that death occurred at 5:54 A.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | |
| ACTUAL SIGNATURE Thomas F. Herbert, M.D. | | | | DATE SIGNED 5-1-61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-3-61 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel | |
| 22d. LOCATION (City, town, or county) Littlestown, Pa. | | | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE MAY 3 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



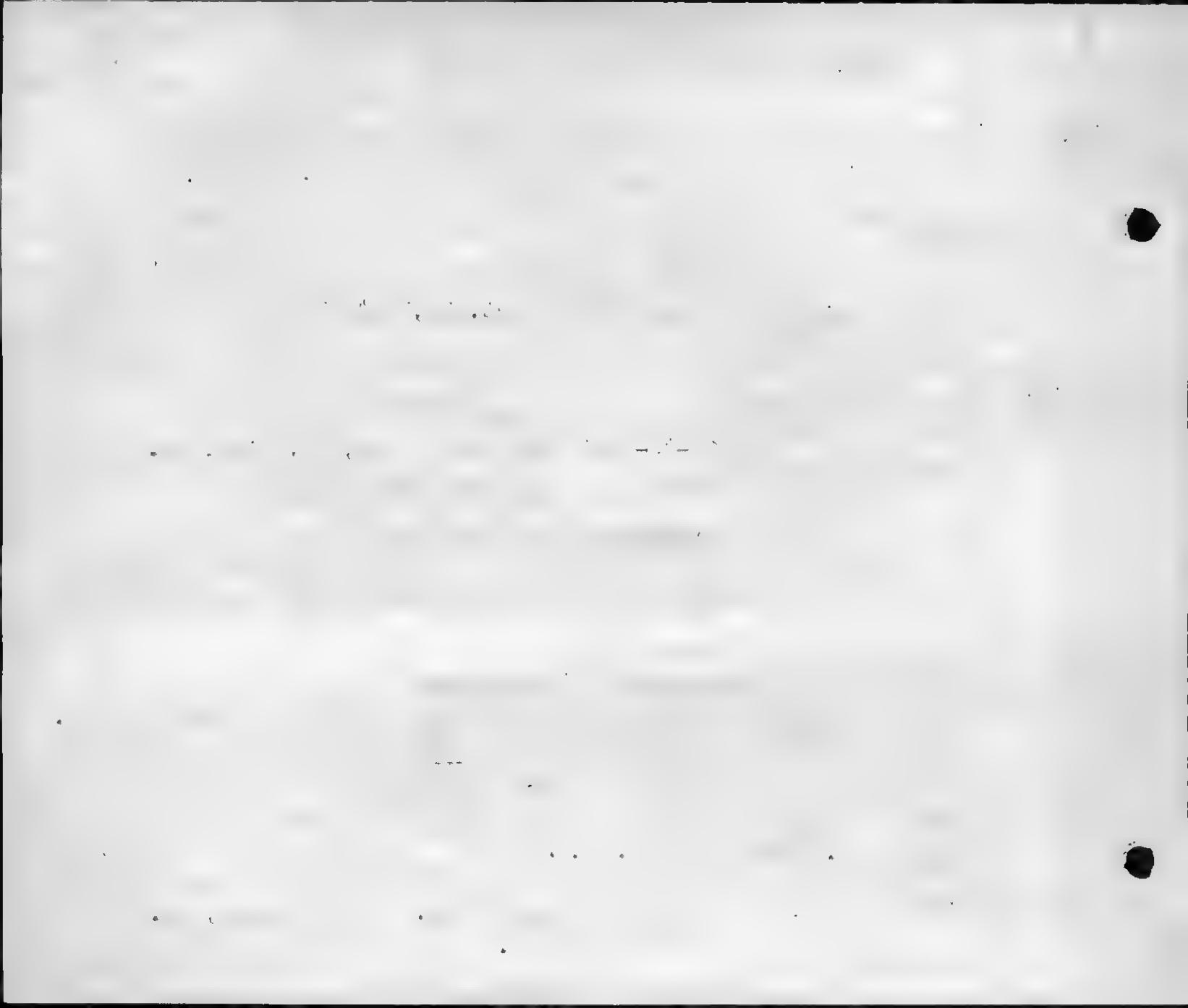
1
FOR STATE
HEALTH DEPT.



DEATH CERTIFICATE: This certificate should be executed within 24 hours after death. If any part of the body is missing, give reason in Item 18. Give legible numbers 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------|---------------------|------|----------|---------------------------------------------------------------|---------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 5701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | | | | | | | | | |
| Howard | | b. STATE Maryland | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | b. COUNTY Howard | | | | | | | | | |
| Poplar Springs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | Poplar Springs, Mt. Airy Rt. 3 | | | | | | | | | |
| Hardy Road | | d. STREET ADDRESS | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | | | |
| RUTH ELOISE MULLINIX | | | | | May 5, 1961 | 19 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | | | | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. | | |
| Female White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Oct. 14, 1924 | 36 | yrs. | Months | Days | Hours | Months Dey Year | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Domestic | | 11. BIRTHPLACE (State or foreign country) | | | | | | | | | |
| 13. FATHER'S NAME | | Long Corner, Md. | | | | | | | | | |
| Millard Fillmore Mullinix | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. 17. INFORMANT | | | | | | | | | |
| No | | Ethel Day Buxton | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | Address | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 10.2 | | DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) | | | | | | | | | |
| | | DUE TO | | | | | | | | | |
| | | (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e. | | 19. WAS AUTOPSY PERFORMED? | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| Overingestion of barbiturates | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| Hour a.m. 5/4 1961 | | While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | Porch of church | | | | Howard | | Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| W. Bradley King, Jr., M.D. | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | DATE SIGNED | | | | | | | | | |
| Burial May 8, 1961 | | 5/6/61 | | | | | | | | | |
| 22b. DATE THEREOF | | Address (Street, city, town, or county) | | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS | | 22d. LOCATION (City, town, or country) (State) | | | | | | | | | |
| Howard Chapel Meth. Damascus, Md. | | Long Corner, Md. | | | | | | | | | |
| 23. FUNERAL DIRECTOR | | 24a. REC'D BY REGISTRAR | | | | | | | | | |
| Olin L. Moxon | | 24b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | DAMAY 9 '61 | | | | | | | | | |
| | | John S. King | | | | | | | | | |
| VS. AT 5ME 5M 7/59 | | | | | | | | | | | |



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05691

1. PLACE OF DEATH

a. COUNTY

Howard

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Woodstock

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Groomes Lane

MARYLAND

c. LENGTH OF STAY IN lb

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY Howard

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Woodstock

d. STREET ADDRESS

Groomes Lane

1. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
May

Day
24
19 61

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

male

white

WIDOWED

DIVORCED

Nov 27 1906

9. AGE (In years
last birthday)
54 yrs.

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY
D.C.A. Machine

11. BIRTHPLACE (State or foreign country)
West Virginia

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

James R. Platt

Dora Shifflett

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank and date of service)

216-A-1525 Mrs Icie Platt Groomes Lane, Woodstock, Md.

INTERVAL BETWEEN
ONSET AND DEATH
15min

no
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

Coronary Thrombosis

Arteriosclerotic cardio vascular disease 11 yrs.

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

George E. Burgtoft

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/24/61

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

burial

5/27/61

Good Shepherd

Ellicott City, Md.

23. FUNERAL DIRECTOR

F.C. Hinbothom Ellicott City, Md.

24a. REC'D BY REGISTRAR

MAY 29 '61

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Thrall



FOR STATE
DEATH DEPT.

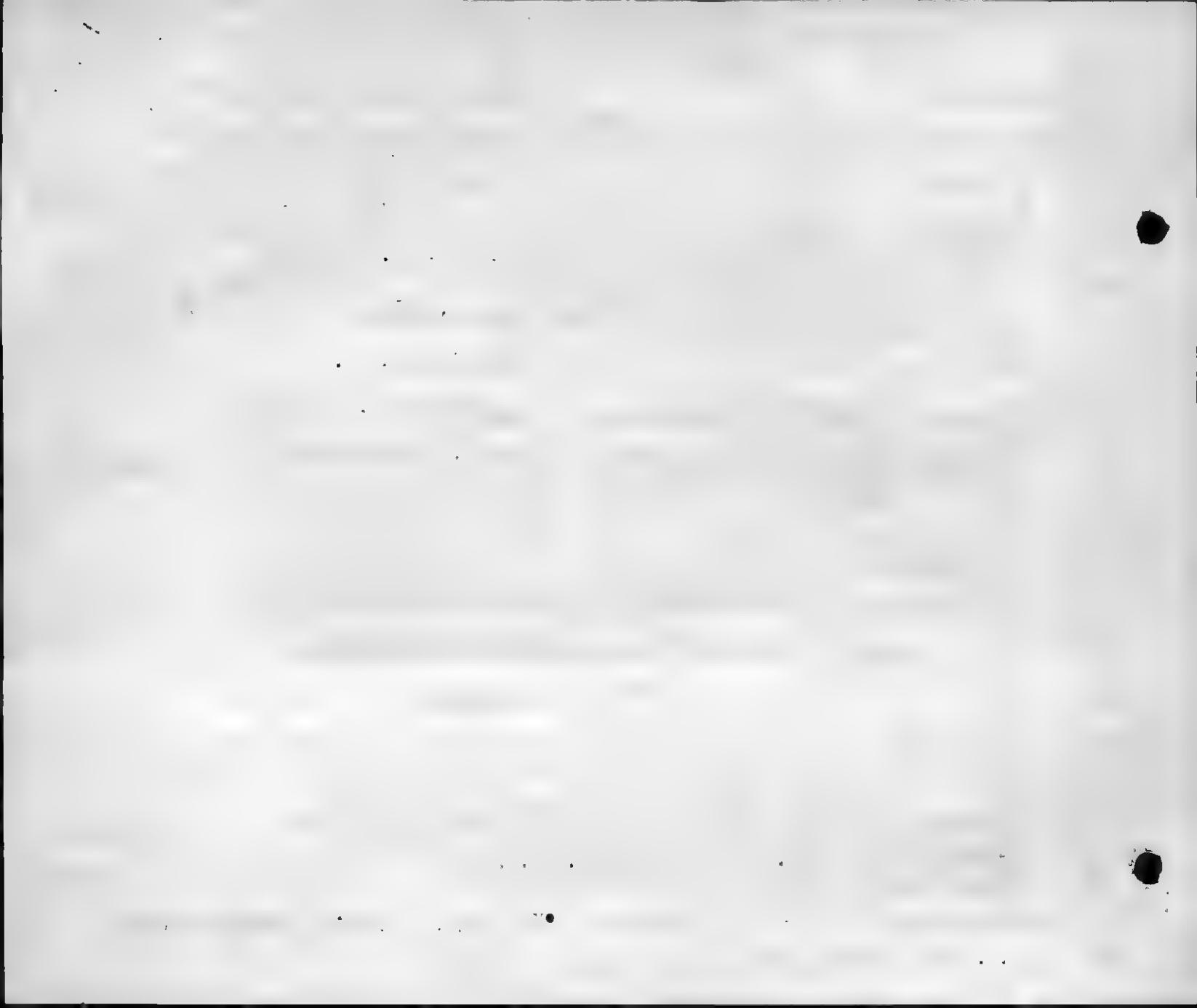
M

TO DIVISION MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15692

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Howard | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | |
| | | b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellitott City | | c. LENGTH OF STAY IN lb | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS Woodlawn X Woodland Farms | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle JAMES Last RHOADES | | 4. DATE OF DEATH May 2 1961 | |
| 5. SEX Male White | | 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH March 8, 1961 | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (in years last birthday) IF UNDER 1 YEAR TF UNDER 24 HRS. Months Days Hours Min. | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Wilmington, Del. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles James Rhoades | | 14. MOTHER'S MAIDEN NAME Margaret F. Goodyear Address | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Charles J. Rhoades, Woodlala | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Otitis media DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | |
| 391.2 | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. | | DATE SIGNED 5/3/61 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-5-61 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hickory Grove | | 22d. LOCATION (City, town, or county) St. Georges, Del. | |
| 23. FUNERAL DIRECTOR F.C. Higinbotham, Ellitott City, Md. | | 24a. REC'D BY REGISTRAR MAY 5 '61 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kinard | |
| | | DATE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

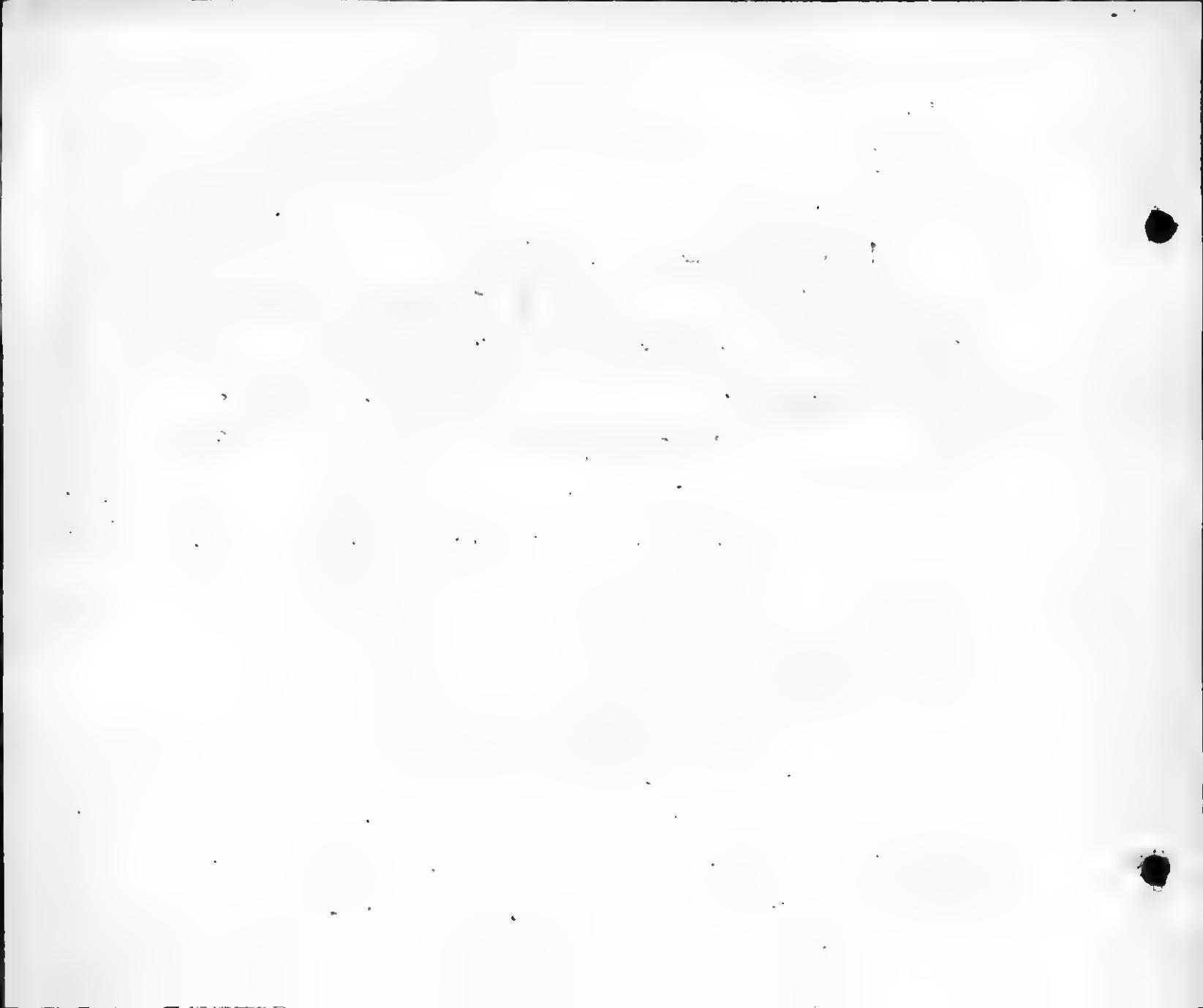
Reg. Dist. No. 05693

5704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Howard</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Daniels</i> | c. LENGTH OF STAY IN TB <i>16</i> | b. COUNTY <i>Howard</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Daniels</i> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#26 Long Brick Row</i> | e. STREET ADDRESS <i>#26 Long Brick Row</i> | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>GEORGE</i> | First <i>U</i> | Middle <i>Rohrback</i> | Last <i>George Rohrback</i> |
| 4. DATE OF DEATH <i>May 16 1961</i> | Month <i>May</i> | Day <i>16</i> | Year <i>1961</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/12/1878</i> |
| 9. AGE (In years last birthday) <i>82 yrs.</i> | 10. KIND OF BUSINESS OR INDUSTRY <i>TEXTILE Mill</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>Daniels, Md</i> |
| 13. FATHER'S NAME <i>Otha Rohrback</i> | 14. MOTHER'S MARRIED NAME <i>Cordelia Morris</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. <i>212-01-9429</i> | INFORMANT <i>Mrs GRACE Rohrback</i> | Address <i>Daniels, Md</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic cardio vascular disease</i> DUE TO (b) <i>4/2/61</i> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>1da.</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Mar. 20</i> , 19 <i>59</i> , to <i>May 16</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>May 15</i> , 19 <i>61</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Thomas F. Herbert</i> | ADDRESS (Street, city or town, state) <i>46 Church Road</i> | | |
| PHYSICIAN'S NAME (Type) <i>Thomas F. Herbert, M.D.</i> | DATE SIGNED <i>5/16/61</i> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>5/19/61</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Locust Valley</i> | 22d. LOCATION (City, town, or county) (State) <i>Middle Town Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. Higginbotham</i> | ADDRESS <i>Ellicott City, Md</i> | 24a. REC'D BY REGISTRAR DATE <i>MAY 18 '61</i> | 24b. REGISTRAR'S SIGNATURE <i>Clara S. Kline</i> |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05694

| | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 5705 | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | MARYLAND | a. STATE | b. COUNTY |
| c. LENGTH OF STAY IN lb | | | Md | HOWARD |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | ELLIOTT CITY | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| e. NAME OF DECEASED (Type or print) | | SCHAFFER CONV. HOME | d. STREET ADDRESS | |
| f. FIRST MIDDLE | | FRANCES B. SMITH | R.D #2 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| g. SEX | | W | g. DATE OF DEATH | Month Day Year |
| h. COLOR OR RACE | | W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 5/18/83 | 1961 |
| i. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days Hours Min. | |
| j. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| DOMESTIC | | | PA. | U.S.A. |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| MICHAEL Mc GUIRN | | KUGLER | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
| | | | MRS. BEATRICE REED | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Immediate | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (e.g., stealing the underlying cause listed.) | | 4 weeks | | |
| (b) | | | | |
| DUE TO (c) | | | | |
| Cerebral Hemorrhage. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| None | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 19 | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 25, 1961, to May 4, 1961, that (I) (We) last saw the deceased alive on April 25, 1961, and that death occurred at 5 P.M. from the causes and on the date stated above. | | 22b. DATE SIGNED 5/4/61 | | |
| 22a. SIGNATURE William F. Gassaway | | M.D. | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM F. GASSAWAY | | 22d. ADDRESS ELLIOTT CITY, MD. | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) CREMATION | | 23b. DATE THEREOF 5/5/61 | 23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK | 23d. LOCATION (City, town or county) BALTO, MD. (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE McMaff & Son | | ADDRESS 78 | 25a. REC'D BY REGISTRAR DATE MAY 8 '61 | 25b. REGISTRAR'S SIGNATURE Arthur S. Turner |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If more than 24 hours elapse between the time of death and the time the physician signs the certificate, it must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5706

CERTIFICATE OF DEATH

65695

Items 3 & 4 filled in 1961 ikw

1. PLACE OF DEATH
a. COUNTY

Howard

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Rural-- Woodbine

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

R. D. # 1

First

MARYLAND

c. LENGTH OF STAY IN 1b

1 ½ Yrs.

3. NAME OF DECEASED
(Type or print)

JESSE

CALVIN

WALKER

Middle

Last

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer, Retired

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

1878

W.DOWED

DIVORCED

Sept. 23, 1877

82 3/4 yrs.

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harry Clinton Walker

Maryland

U. S. A.

14. MOTHER'S MAIDEN NAME

Agenette Kaiser

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank and dates of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

219-20-9074 Mr. Earl E. Walker, Same as # 2

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO
Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

Coronary thrombosis, arteriosclerosis
generalized.

Jan 61
to

1 May 61

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e). 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH!
(IF EITHER, NOTIFY MEDICAL EXAMINER)

| | | | | |
|-----------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------|
| 2Dc TIME OF INJURY Hour a.m. p.m. | Month, Day, Year 19 | 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 2Dc PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 2Df. (City or town) (County) (State) |
|-----------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------|

21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to 1 May 1961, that (I) (we) last saw the deceased alive on 1 May 1961, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Howard E. Hall

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
1 May 61

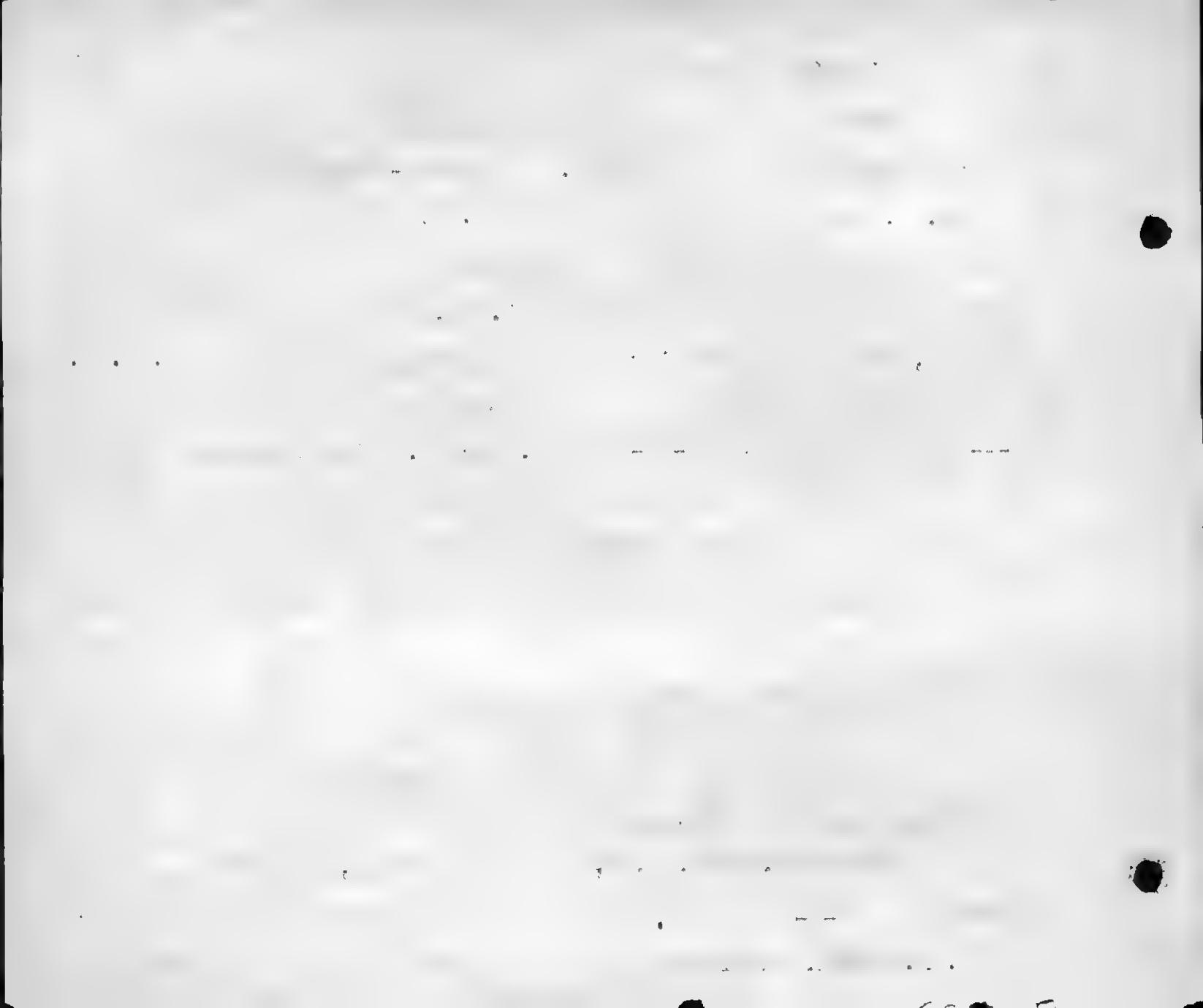
22c. PHYSICIAN'S
NAME (Type)

Howard E. Hall, M. D.

Sykesville, Maryland

| | | | | |
|-----------------------------------------------------|-------------------------------|-------------------------------------------------------------|-------------------------------------------------------------|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-4-1961 | 23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery | 23d. LOCATION (City, town or county) Frederick, Maryland | (State) |
|-----------------------------------------------------|-------------------------------|-------------------------------------------------------------|-------------------------------------------------------------|---------|

| | | | |
|-----------------------------------------------------------|---------|-------------------------------------------|------------------------------------------------|
| 24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield | ADDRESS | 25a. REC'D BY REGISTRAR DATE MAY 3 '61 | 25b. REGISTRAR'S SIGNATURE Arthur S. Thorne |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

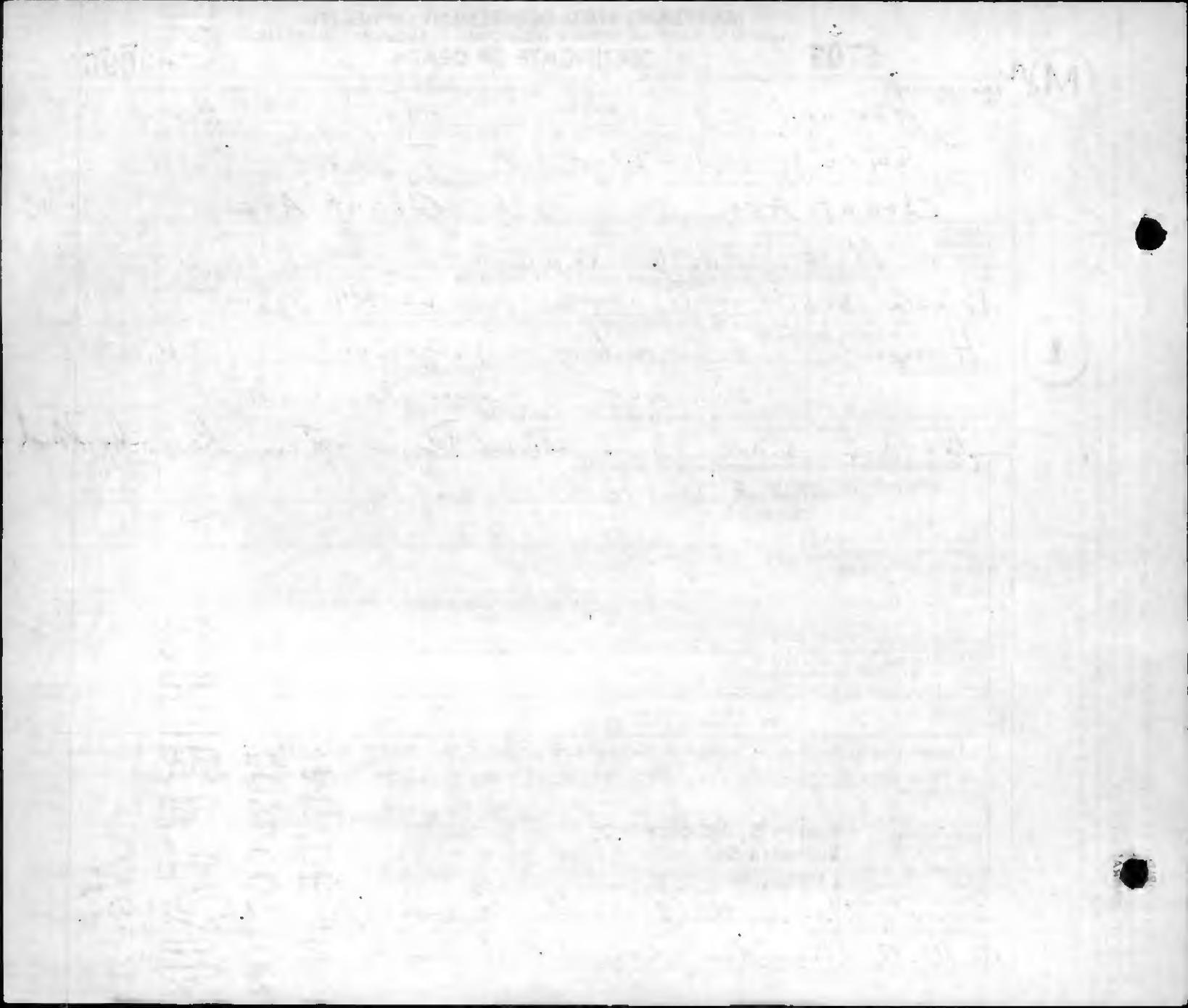
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5707

65696

| | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | |
| <i>Howard</i> | | MARYLAND <i>Md</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb <i>Rural - Rural 20 yr</i> | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS <i>Fairfax - Rural</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grant Ave</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Nora</i> | Middle <i>Edith</i> | Last <i>Whiting</i> | |
| 4. DATE OF DEATH | Month <i>May</i> | Day <i>9</i> | Year <i>1961</i> | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 22, 1884</i> | |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday) <i>76 yrs.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housing</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Henry</i> | 14. MOTHER'S MAIDEN NAME <i>Sara Margaret</i> | Address <i>Mrs Dunwoody, Laurel Md</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>Charmine Moysachko</i> | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) <i>Glennville</i> (State) <i>W. Virginia</i> | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>April 5, 1960</i> to <i>May 9, 1961</i> , that (I) (we) last saw the deceased alive on <i>May 9, 1961</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above. | | | | 22b. DATE SIGNED |
| 22a. SIGNATURE <i>Robert S. McCeney</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (Type) <i>ROBERT S. MCCENEY M.D.</i> <i>402 MAIN ST.</i> | | 22d. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE THEREOF <i>May 11, 1961</i> | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Glenville Cemetery</i> | 23d. LOCATION (City, town, or county) <i>Glenville, W. Virginia</i> | (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Donaldson, Laurel, Md</i> | | ADDRESS | 25a. REC'D BY REGISTRAR <i>May 15 '61</i> | 25b. REGISTRAR'S SIGNATURE <i>Ching S. Kuan</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------|------------------|----------------------------|---------|------|--|
| 5708 | | | | | | 05697 | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | | | | |
| Howard | | Maryland | | Md. | | Howard | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | | | | |
| Rural Rocksville | | Life | | Rocksville | | X Rocksville | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | | | |
| Ebsie | | | | May Wilson | May 28 | 1961 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. UNDER 1 YEAR IF UNDER 24 HRS. | Months | Days | Hours | Min. | |
| F. | | Col. | | Jan. 1 1889 | 72 yrs. | 11. BIRTHPLACE (State or foreign country) | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| Housewife | | Home | | Md. | | U. S. A. | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John Hall | | Emma Smith | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| | | | | Donald Wilson - Rocksville, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| 443 X DUE TO ② Pulmonary Edema - Hypertension Anterior & Posterior Heart Disease with Congestive failure ③ Hypertension 6 weeks | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ④ Myocarditis 3 grs + (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | | |
| 19 | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 28 Feb 1959 to 28 May 1961, that (I) (we) last saw the deceased alive on 13 May 1961, and that death occurred at 12:00 M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED | | | | |
| C. R. Davidson | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | 305A Winters Lane | | | | | | | |
| Charles R. Davidson | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION (City, town, or county) | | (State) | | | |
| Burial | | 5-30-61 | | Hopkins Chapel | | Hyde Park, Howard, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Arthur J. Haught | | Lyndale, Md. | | | | DATE MAY 31 '61 | | Arthur S. Knudt | | | |

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